Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2355SNF	A. BUILDING _____ B. WING _____	C 03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 3/9/10 and finalized on 3/16/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00024648 was substantiated with deficiencies cited. (See Tags Z 230 and Z 265) Complaint #NV00024660 was unsubstantiated with unrelated deficiencies cited. (See Tag Z 230) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000		
Z230 SS=D	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2355SNF	A. BUILDING _____ B. WING _____	C 03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 1 developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure laboratory tests (complete blood count and basic metabolic panel) were done as ordered for 1 of 4 residents (Resident #1) and failed to ensure that a Fentanyl patch for pain was promptly available following the physician order for 1 of 4 residents (Resident #2). Severity: 2 Scope: 1	Z230		
Z265 SS=G	NAC 449.74477 Pressure Sores Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that a patient: 1. Who is admitted to the facility without pressure sores does not develop pressure sores unless the development of pressure sores is unavoidable because of the medical condition of the patient; and This Regulation is not met as evidenced by: Based on record review, policy and procedure review, and interview the facility failed to ensure residents admitted to the facility without pressure sores did not develop pressure sores and failed to assess and monitor the development of a pressure sore in accordance with facility policy for 1 of 4 residents (Resident #2). Findings include: Record review revealed Resident #2 was admitted to the facility on 1/14/10, following a hospitalization. Her diagnoses included normal pressure hydrocephalous, abdominal pain,	Z265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2355SNF	A. BUILDING _____ B. WING _____	C 03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z265	Continued From page 2 osteoporosis, and senile dementia. Review of Resident #2's record revealed a stage II pressure sore was identified on the resident's coccyx measuring 2 cm x 2 cm with 0 cm depth on 2/1/10. An order for treatment was obtained and DuoDerm was applied. On 2/5/10, an order was written for an air mattress. On 2/10/10, the wound had increased in size to 3 cm x 2 cm with a depth of 0.5 cm. New orders for treatment and included a referral to the wound clinic. Review of Resident #2's record revealed an admission skin assessment was completed on 1/14/10; a rash to the groin area was documented. Further review of the record failed to reveal weekly skin assessments were done. The Skin Integrity Evaluation form was not found. Review of the medication administration records (MAR) revealed that the area for the weekly skin assessments to be documented was blank for the months of January and February 2010. Review of the resident's care plans revealed that a care plan entitled, "alteration in skin integrity secondary to" was blank and had not been initiated. The facility's policy and procedure for skin integrity was reviewed. Review of the procedure revealed the resident's skin integrity is to be evaluated on admission and weekly for the three weeks following admission. Section II of the form is to be completed "no later than after the evaluation for Week 3 is completed." Nursing is then to establish a care plan using the skin integrity impairment care plan as a guide. The nurse is to complete a weekly visual skin inspection and any "skin ulcers/pressure ulcers/bruises/skin tears/incisions/wounds are to be documented on the Wound/skin evaluation	Z265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2355SNF	A. BUILDING _____ B. WING _____	C 03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORMSBY POST ACUTE REHAB	3050 N ORMSBY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z265	Continued From page 3 and documentation form when identified and weekly thereafter until resolved." Severity: 3 Scope: 1	Z265		